Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
is a second of the second of t		A. BUILDING:	A. BUILDING:		COIVII LETED	
		005008	B. WING		05/1	11/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST CATHE	RINE HOSPITAL INC	4321 FIR FAST CH	ST ICAGO, IN 463	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS	•	S 000			
	This visit was for inve					
	Complaint Number: IN00158698 Substantiated: deficiency cited related to allegations.					
	Date: 5/11/15					
	Facility Number: 005	5008				
	QA: cjl 06/08/15					
S 930	410 IAC 15-1.5-6 NU	RSING SERVICE	S 930			6/29/15
	410 IAC 15-1.5-6 (b)(	(3)				
	(b) The nursing service shall have the following:					
	(3) A registered nurse and evaluate the care provided to each pati	e planned for and				
	registered nurse faile the nursing care for e inaccurate wound do weekly, and/or prior t and 2) closed patient	review and staff interview, a d to supervise and evaluate				
	Findings:					
	1. Policy #PCS-EBN	P 1.0, Pressure Ulcer				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		005008	B. WING		0.	5/11/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	-	
ST CATHI	ERINE HOSPITAL INC	4321 FIF	R ST			
31 CAIIII	ENINE HOSPITAL INC	EAST C	HICAGO, IN 46312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
S 930	Prevention Assessmerevised/reapproved 1 ulcers/wounds are to measured, and docur weekly, if wound dete to provide a systematic process for skin integers. Review of closed arecords, confirmed:  A. patient #1 was a. a. skin assessmer was clean, dry, and ir. b. on 7/18/14 at 13 documented as coccy 0.5 cm (length) x 0.3 c. Physical Therap wound again on 7/21. (width); 7/26/14, 8.5 cm (length); 7/26/14, 8.5 cm (length); 7/26/14, 8.5 cm (length) x 2 cm assessed again before. lacked photogra and at discharge for the scrotal tear. f. Patient was discensed as a. on 8/26/14, a w stage I decubitus ulcearea; no measurement b. on 8/31/14, presensed again tented as stage II left buttool x 1 cm (width); stage cm (length) x 1.1 cm (medial), 0.3 cm (length) con 8/31/14 cm (medial), 0.3 cm (length)	ent and Treatment, /2014, indicated pressure be accurately assessed, mented on admission, erioration, and at discharge ric approach and monitoring rity/pressure ulcer care.  and open patient medical dmitted on 7/16/14 and: at on 7/16/14 indicated skin natact.  353 hours, a wound was yx stage II pressure sore, cm (width). bist (PT) measured this (PT) measured this (PT) measured this (PT) measured this (width), but was not be discharge. The discharge aphs on admission, weekly, both the coccyx wound and charged to hospice care on dmitted on 8/26/14 and: ound was documented as er in sacral and buttocks	S 930			

Indiana State Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			5 4//140			
005008		B. WING		05/11/2015		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST CATHE	RINE HOSPITAL INC	4321 FIR S				
			CAGO, IN 4631			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 930	Continued From page	2	S 930			
	c. lacked photogra and at discharge for a measurements prior t 9/7/14.	iphs on admission, weekly, all wounds and no further o discharge home on				
	a. on 4/29/15, pho wound documented a cm (length) x 3 cm (w blank, 0.5 cm (length)	dmitted on 4/29/15 and: tographs were taken for a is stage II, location blank, 2 ridth); stage II, location ) x 0.6 cm (width); stage II,				
	a wound with no local b. on 4/30/15, a ph	notograph was taken of a				
	c. lacked photogra	cation and measurement.  Supply and supply anative supply and supply and supply and supply and supply and supp				
	5/11/15.	chia phor to survey on				
	a. on 5/8/15, a pho wound documented a (length) x 1.5 cm (wid present on admission b. lacked assessm	dmitted on 5/4/15 and: btograph was taken for a is stage II buttock, 2.5 cm lth) and was documented as inent and photographs on ither measurements prior to				
	a. on 4/22/15, a we coccyx, lacked measu	dmitted on 4/22/15 and: ound was documented as urements. otographs were taken of				
	wounds, but lacked d and measurement. c. lacked assessm	ocumentation of location ent and photographs on				
	survey on 5/11/15.	ther measurements prior to				
		care Specialist) was 5 at approximately 1427 photographs of wounds are				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
	005008	B. WING		05	5/11/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE			
ST CATHERINE HOSPITAL INC	4321 FIR EAST CH	ST IICAGO, IN 46312				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5)			
not accurately assess, n	rs/wounds for patient's 1,	S 930				

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